D H E C
PROMOTE PROTECT PROSPER

HEALTH HISTORY

Side 1

If you do not know your family history, skip to Section 2.

Section 1: Family History

Check all the boxes that apply for parents, grandparents, brothers, sisters & children (living or dead).

- ☐ Heart disease/heart problems
- ☐ High blood pressure/stroke
- ☐ High cholesterol
- ☐ Diabetes (high blood sugar)
- ☐ Depression/anxiety
- ☐ Cancer of the breast
- ☐ Cancer of the ovaries
- ☐ Other cancer (List type below)
- ☐ Tuberculosis (TB) infection/disease
- ☐ Mental health concerns
- ☐ Birth defects/genetic problems
- ☐ Lung problems
- ☐ Sickle cell anemia/trait
- ☐ Obesity

List other illnesses/problems in your family: _____

Section 2: Allergies

If you are here for yourself, list the allergies you have. If you are here for your child, list the allergies your child has.

Allergies? ☐ No ☐ Yes If yes, check all that apply.

☐ Medicine(s) ☐ Latex ☐ Food ☐ Bee or other insects ☐ Other

List what the allergy is to and the reaction: _____

Section 3: Personal Medical History

If you are here for yourself, check all the boxes that apply to you now or in the past. If you are here for your child, check all the boxes that apply to your child now or in the past.

- ☐ High blood pressure
- ☐ Stroke
- ☐ Blood clots legs/lungs/eyes (Circle all that apply)
- ☐ Heart problems/heart disease
- ☐ High cholesterol
- ☐ Diabetes (high blood sugar)
- ☐ Thyroid disease/goiter
- ☐ Liver problems
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Gallbladder disease/gallstones
- ☐ Stomach problems
- ☐ Kidney problems
- ☐ Lung problems
- ☐ Asthma
- ☐ Tuberculosis (TB) infection/disease
- ☐ Chickenpox
- ☐ Cancer (List type below)
- ☐ Breast problems
- ☐ Seizures/convulsions (How often?) _____
- ☐ Severe headaches/migraines
- ☐ Glasses/contacts/laser surgery (Circle all that apply)
- ☐ Dental problems
- ☐ Depression/anxiety
- ☐ Eating disorder
- ☐ Mental health concerns
- ☐ ADHD/hyperactivity
- ☐ Learning problems
- ☐ Birth defects/genetic problems
- ☐ Hemophilia (free bleeder)
- ☐ Sickle cell anemia/trait
- ☐ Anemia (low blood or low iron)
- ☐ HIV/AIDS
- ☐ Sexually transmitted infections
- ☐ Pelvic infection (uterus/tubes)
- ☐ Fibroid
- ☐ Endometriosis
- ☐ Major surgery
- ☐ Experienced sexual or physical abuse
- ☐ Felt unsafe with anyone
- ☐ Used street drugs (marijuana, cocaine, heroin, etc.) (Circle all that apply)
- ☐ Drink alcohol/beer/wine (Circle all that apply)
- ☐ Smoke/chew/dip tobacco (Circle all that apply)

List other illnesses/problems that require medication, treatment or hospitalization: _____

Client's ID Number: _____

Client's Name: LABEL

Client's Date of Birth: _____

(Side 1)

Section 4: Reproductive Health History

Men and Women: Please answer the following

Have you ever had sex? ☐ Yes ☐ No

Your age the first time you had sex: _____

Check the methods of birth control you use now or have used in the past.

☐ None	☐ Condoms	☐ Lunelle shot	☐ Ring	☐ Tubal Ligation (tubes tied)
	☐ Depo Provera shot	☐ Norplant	☐ Rhythm	☐ Vasectomy
☐ Abstinence (no sex)	☐ Diaphragm	☐ Other _____	☐ Spermicide (foam, jelly, film)	☐ Withdrawal
☐ Birth Control Pills	☐ IUD	☐ Patch	☐ Sponge	

Did you have problems with any of these methods? If so, list the method and the problems you had.

Section 5: Health Histroy For Women Only

Women: Please answer the following.

Age when period started: _____ How much do you bleed? ☐ Heavy ☐ Medium ☐ Light

Average number of days you bleed: _____ Did your mother take DES between 1940-1970? ☐ Yes ☐ No ☐ Unknown

Have you ever had a rubella vaccine (german measles vaccine)? ☐ Yes ☐ No

About your pregnancies: (Check all that apply)

☐ Miscarriage over 20 weeks? How many? _____

☐ Elective abortion? How Many? _____

☐ Stillborn? How many? _____ How many weeks? _____

☐ Preterm labor? How many weeks? _____

☐ Preterm delivery (over 3 weeks early)? How many weeks? _____

☐ Gestational diabetes (sugar during pregnancy)

☐ High blood pressure during pregnancy

☐ Postpartum blues

☐ Diagnosed postpartum depression

☐ Baby died before 1 year old

Pregnancy History

Date of Birth	# Months or # Weeks	Sex	Birth Weight	Problems

Section 6: Birth HHistory for Children

Complete the following section if you are here for your child?

What did your child weigh at birth?

Were there problems at birth? ☐ Yes ☐ No

If yes explain:

Stop Here

Provider Comments/Updates: _____

Patient Signature	Staff Signature	Date

Client's ID Number: _____

Client's Name: _____ LABEL

Client's Date of Birth: _____

SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIRONMENTAL CONTROL
Health History Form - DHEC 1859 -Instructions for Completing- Rev. 12/2006

Purpose:
To provide a uniform system for collecting a health history to be used in the delivery of health services.

Explanation and Definition:
The form is to be used for patients receiving public health services and is adequate for more than one year of service. The extent of the information collected will depend on the patient and the reason for services. All items are to be completed in black ink. Refer to program guidelines to determine when this form is to be initiated.

General Instructions for Use:
The Health History Form is to be completed by the patient or caregiver initially. If the patient or caregiver is unable to complete the form, the health professional will complete it. In subsequent years, the health professional will review and update the form with the patient, per program guidelines.

The patient will complete the appropriate sections.
Adult men and women presenting for the first time should complete: Section 1: Family History; Section 2: Allergies; Section 3: Personal Medical History; Section 4: Reproductive Health History.

Adult women should also complete Section 5: Health History of Women.

Children presenting for the first time should complete: Section 1: Family History; Section 2: Allergies; Section 3: Personal Medical History; and Section 6: Birth History for Children.

Upon completion of the form by the patient or caregiver, the health professional reviews the health history. Pertinent questions are asked to clarify the information provided. The health professional documents clarifying information on the form as needed.

In subsequent years, the form is reviewed and updated. Any item that is updated must be dated and initialed.

Note: For family planning patients, the person providing the physical examination must document that they have reviewed the health history.

Provider Comments Updates:
Any additional comments/updates can be documented in "provider comments/updates".

Patient Signature/Staff Signature/Date:
The patient signs the signature line indicating completion of the form. If the patient is unable to complete the form, draw a line through the patient signature line. The staff person reviewing the history (or completing the history if the patient is unable) signs his/her legal signature (first initial, full surname and credentials). Enter the month/day/year the health history was reviewed/updated. In some cases it is acceptable for one nurse to assist the client (i.e., LEP) in completing the health history as long as the APRN or Expanded Role RN who does the physical examination also reviews the history and signs the form. In this instance two signatures would be documented on the form.

In subsequent years, the patient signs when form is reviewed and the staff person reviewing/updating the form signs and dates the form.

Office Mechanics and Filing:
Refer to the most recent Comprehensive Health Records Manual for filing and disposition instructions.